

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029433

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 251

FILED JUL 19 1963

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pettis</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u> | | c. CITY OR TOWN <u>Sedalia</u> | |
| Length of stay in lb <u>14 yrs</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>1001 So. Beacon</u> | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Estella Sally Giddens</u> | | 4. DATE OF DEATH Month Day Year <u>July 14, 1963</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-4-1885</u> |
| 9. AGE (last birthday) <u>78</u> | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (City and state or country) <u>Allentown, Pa</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Moyer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Chas. A. Giddens</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Chas. A. Giddens</u> | | Address <u>1001 So. Beacon</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Roy Wilhite</u> | | Address <u>1001 So. Beacon</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> | |
| DUE TO (b) <u>arteriosclerotic Heart Disease</u> | | <u>10 years</u> | |
| DUE TO (c) <u>—</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>—</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>1953</u> to <u>13 July 63</u> and last saw her alive on <u>13 July 1963</u> Death occurred at <u>3</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Charles R. Edwards M.D.</u> | | 22b. ADDRESS <u>Sedalia, Missouri</u> | 22c. DATE SIGNED <u>15 July 63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>July 16, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | 23d. LOCATION (City, town, or county) <u>Sedalia Mo.</u> |
| 24. FUNERAL DIRECTOR <u>W. Langhlin Bros</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 15, 1963</u> | 26. REGISTRAR'S SIGNATURE <u>Frances Shelby Per</u> |
| ADDRESS <u>579 So Ohio</u> | | <u>H. Anderson</u> | |

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 0808

2 0808

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

Edwards

AUG 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed K.P. McHenry
Licensed Embalmer No. 3153

P. O. Address Sedalia, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.